Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-099

Prepared by: New York City Regional Office

Issue Date: Mar 10, 2022

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 09/08/2021
Initial Date OCFS Notified: 09/08/2021

Presenting Information

The BF and SC's caretaker were aware that the SC had a fever and pneumonia for 5 days. As of 9/8/21, neither the BF nor the caretaker sought the needed medical attention for the SC. At an unknown time on 9/8/21, the SC became unresponsive in the home while in the care of his caretaker. The caretaker called 911 when the SC became unresponsive. When EMS arrived at the home, the SC was in cardiac arrest. The SC was transported to a local hospital and died on 9/8/21 at 9:55 PM. The cause of death was unknown. The BF and the caretaker's failure to seek timely medical treatment for the SC was believed to have contributed to his death.

At the time of his death, the SC had bruising on his lower thigh and on his lower stomach. He also had burn marks on one of his arms. The injuries were suspicious as they appeared to have been inflicted and not caused accidentally. The BF, the caretaker, and the SC's other caretaker were the alleged subjects as they were the SC's primary caregivers.

Executive Summary

On 9/8/21, the 16-year-old SC died. The preliminary information from the ME cited the cause of death as pneumonia.

At the time of the SC's death, the BF had legal custody of the SC. The SC did not have any surviving siblings. The BF hired three nannies to assist with 24-hour childcare for the SC while he worked.

On 9/8/2021, ACS received the report and initiated the CPS investigation in a timely manner. ACS learned that five days prior to his passing, the SC had a fever and was taking over the counter (OTC) cold medications but was not taken for medical care. The SC's caregiver (who for the purpose of this report shall be referred to as Nanny 1) was caring for the SC at the time. At about 12:00PM, the SC became unresponsive and went into cardiac arrest. Nanny 1 called 911. The 911 operator instructed Nanny 1 how to give the SC CPR over the phone. EMS responded to the home minutes later and continued CPR on the SC. EMS transported the SC in an ambulance to an area hospital where he was resuscitated and then transferred to a specialized hospital for a higher level of care. The SC arrived at the specialized hospital in critical condition. He did not have any neurological function and had experienced multiple cardiac arrests. He had bruises to his extremities and broken blood vessels on his chest. At 9:55PM, medical staff pronounced the SC deceased.

ACS obtained information from collaterals such as the SC's Nannies, the parents, hospital staff, LE, and medical providers, which did not reveal the caretakers were negligent regarding the SC's death. The collaterals reported the SC was severely autistic and was prescribed medication. The SC was well cared for. The medical providers stated Nanny 1 acted appropriately when he found the SC unresponsive, and he called 911. LE did not make any arrests pending the final autopsy report.

On 10/22/2021, ACS UNSUB the allegations of the report due to lack of credible evidence. ACS based its decision on the ME's preliminary findings which stated the cause of death was pneumonia. The ME did not deem the bruising and marks on the SC's body suspicious pending the results of further tests. Additionally, the attending physician stated it was impossible to tell that the outcome could have been different if medical treatment was sought sooner for the SC. The physician deemed the caregivers' decision to treat the SC's fever with OTC medication was reasonable based on the SC's illness at the time.

ACS provided the BM with information regarding bereavement services. Also, ACS utilized language services to engage the SC's nannies who had limited proficiency in English language.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS' decision to close the case was appropriate. There were no surviving siblings.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/08/2021 **Time of Death:** 09:55 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **Not Applicable**

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	61 Year(s)
Other Household 1	Mother	No Role	Female	56 Year(s)
Other Household 2	Other - Nanny 1	Alleged Perpetrator	Male	58 Year(s)
Other Household 3	Other - Nanny 2	Alleged Perpetrator	Male	60 Year(s)
Other Household 4	Other - Nanny 3	Alleged Perpetrator	Female	53 Year(s)

LDSS Response

On 9/8/21, the medical staff stated the SC had several cardiac arrests before being stabilized and transferred to a specialized hospital. The SC had fresh bruises and burn marks on his body.

On 9/8/21, Nanny 1 stated that sometimes in the morning of 9/6/2021, the SC had a fever and a cough. He notified the BF about the SC's condition and then discontinued the SC's prescribed medication. He gave the SC an OTC medication which the BF had brought to treat the SC's symptoms. At about noon on 9/8/21, Nanny 1 noticed that the SC was unresponsive and called 911. The 911 operator instructed Nanny 1 to give the SC CPR until EMS' arrival. He stated the SC likely sustained bruises on his body from his unstable walking patterns, as the SC would walk into household items.

On 9/8/21, Nanny 3 stated the SC would walk into furniture and other items after taking some of his medication. The SC scratched, hit himself and would pick the scars on his skin when he got angry.

On 9/8/21, the attending doctor (Dr.) stated the SC arrived at the hospital in critical condition with no neurological functioning. He had multiple bruises on his extremities and had experienced multiple cardiac arrests. The SC was resuscitated, but the family elected not to resuscitate him any further.

On 9/8/21, ACS and LE interviewed the BF who confirmed the SC had a medical condition and was on medication. The BF last saw the SC on 9/7/21 but he did not check the SC's body as the SC was asleep at the time. He stated it was routine for the SC to have a cold which was usually treated with the OTC medication. The SC saw his PCP for his back-to-school check-up. The appointment was uneventful.

On 9/8/21, the PA did not have any concerns about the care the SC received.

On 9/9/21, ACS made contact with the BF, Nanny 1, and Nanny 3 at the case address. The BF denied any challenges caring for the SC. The SC received services in school. The BF stated the SC sometimes bumped into household items and would hit himself when he got upset. This was the only possible reason for the SC's bruises.

Nanny 1 and Nanny 3 repeated the account of events leading up to the fatality which was consistent with the account they previously reported to ACS.

On 9/9/21, the ME reported the preliminary cause of death was pneumonia. The ME did not deem the bruising and marks on the SC's body suspicious pending toxicology results.

On 9/10/21, EMS reported the SC had fresh bruises on his body and cigarette burns on his forearms.

On 9/23/21, the BF directed ACS to henceforth speak to his attorney. He provided ACS with the attorney's contact information.

On 9/30/21, ACS notified the BM that her son had passed and that the preliminary cause of death was pneumonia, pending the toxicology report.

On 10/8/21, the SC's PCP reported the SC was last seen on 8/3/21 and his immunizations were current. The SC was diagnosed with multiple clinical health conditions and was on prescribed medication. The PCP deemed the prescribed medication appropriate for the SC's diagnosis.

On 10/8/21, Nanny 2 stated he suggested to Nanny 1 to take the SC to the doctor when the SC had a fever. Nanny 1 reported he already spoke to the BF about the SC's condition and the BF bought OTC medication to treat the SC's fever.

On 10/15/21, ACS offered the BM information regarding bereavement services. The BM was receptive to ACS' offer.

On 10/19/21, the ACS medical consultant confirmed the SC's medication was consistent with his diagnosis.

On 10/19/21, the medical staff stated it was impossible to tell that the outcome could have been different if medical treatment was sought sooner for the SC. The BF and the caregivers' decision to treat the SC's fever with OTC medication was reasonable based on the SC's illness at the time.

On 10/22/21, ACS UNSUB the allegations of the report due to lack of credible evidence.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059686 - Deceased Child, Male, 16 Year(s)	059688 - Father, Male, 61 Year(s)	DOA / Fatality	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059722 - Other - Nanny 1, Male, 58 Year(s)	DOA / Fatality	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059688 - Father, Male, 61 Year(s)	Lack of Medical Care	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059722 - Other - Nanny 1, Male, 58 Year(s)	Lack of Medical Care	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059688 - Father, Male, 61 Year(s)	Burns / Scalding	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059688 - Father, Male, 61 Year(s)	Inadequate Guardianship	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059688 - Father, Male, 61 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059722 - Other - Nanny 1, Male, 58 Year(s)	Burns / Scalding	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059722 - Other - Nanny 1, Male, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059722 - Other - Nanny 1, Male, 58 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059723 - Other - Nanny 2, Male, 60 Year(s)	Burns / Scalding	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059723 - Other - Nanny 2, Male, 60 Year(s)	Inadequate Guardianship	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059723 - Other - Nanny 2, Male, 60 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059724 - Other - Nanny 3, Female, 53 Year(s)	Burns / Scalding	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059724 - Other - Nanny 3, Female, 53 Year(s)	Inadequate Guardianship	Unsubstantiated
059686 - Deceased Child, Male, 16 Year(s)	059724 - Other - Nanny 3, Female, 53 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐

Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☐	☐	☐	☒	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐

Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
There were no services required.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/29/2020	Deceased Child, Male, 16 Years	Father, Male, 60 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 16 Years	Father, Male, 60 Years	Poisoning / Noxious Substances	Unsubstantiated	

Report Summary:
There was a concern that on more than one occasion, the BF gave the SC surplus of medication. As a result of the BF's actions, the SC shook and looked pale.

Report Determination: Unfounded | **Date of Determination:** 02/24/2021

Basis for Determination:
ACS determined that the BF ensured that the SC' basic needs were being met. The SC had 2 nannies that were with him every day while the BF was at work. The nannies stated the SC was well cared for and they did not have any concerns for the SC. The SC's school and doctor reported that the SC was well cared for and there were no concerns for him. ACS observed the SC to be always free of any marks or bruises. ACS counseled the BF about Office for People with Developmental Disabilities services for the SC. He declined services.

OCFS Review Results:
ACS' determination of UNF was consistent with the investigation findings.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

01/09/2020	Deceased Child, Male, 15 Years	Father, Male, 60 Years	Lack of Medical Care	Unsubstantiated	No

Report Summary:
The report alleged the SC had dental concerns. The SC's molars were rotten and infected. The BF was aware and failed to follow through with medical care for the SC.

Report Determination: Unfounded | **Date of Determination:** 03/09/2020

Basis for Determination:
The BF ensured that the SC had adequate medical care. The SC saw his doctors when needed. The medical care provider did not report any concerns for the SC. Also, the dentist confirmed that the SC's dental care was up to date. The SC attended school regularly and received school-based services. He had a home health aide and a PU who provided care after school while the BF was at work. ACS assessed the SC to be happy and free of any visible suspicious marks or bruises on his person. He appeared well nourished. There was adequate food in the home and the SC's needs were being met.

OCFS Review Results:
NYCRO agrees with the case determination of UNF due to lack of credible evidence to support the concerns reported.

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/06/2019	Deceased Child, Male, 14 Years	Mother, Female, 54 Years	Other	Unsubstantiated	No
	Deceased Child, Male, 14 Years	Father, Male, 59 Years	Other	Unsubstantiated	

Report Summary:
On 3/6/2019, Queens County Family Court ordered a 1034 Court Ordered Investigation with the concerns that the SC did not have appropriate clothing and care.

Report Determination: Unfounded | **Date of Determination:** 05/02/2019

Basis for Determination:
During the investigation, ACS did not find any evidence that the SC was being neglected or abused. The medical providers and school staff did not report any concerns for the SC. The SC was well taken care of by the nannies hired by the BF to care for the SC when he was at work and unable to care for him. The nannies were cleared and deemed suitable. The SC had appropriate clothing and was being properly fed at school and at home.

OCFS Review Results:
Based on the case documentation, there were no safety concerns for the SC at the time of th investigation.

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/25/2018	Deceased Child, Male, 13 Years	Father, Male, 58 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 13 Years	Father, Male, 58 Years	Sexual Abuse	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 52 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
The report alleged the SC had lesions on his mouth and infections on spots on his body. The SC also had herpes on his private part. The SC was being sexually abused by his caretakers, the BM, and/or the BF. The SC resided with his BF and had visitation with the BM.

Report Determination: Unfounded | **Date of Determination:** 07/06/2018

Basis for Determination:
During the investigation, the BF denied sexually abusing his son and denied that his son had herpes. The SC's home aide denied any concerns about the care the BF provided the SC. The pediatrician denied the SC had herpes in his mouth or on his genitalia or any other sexually transmitted disease. The SC's basic needs for food, clothing, shelter, medical needs, educational and supervision needs were being met by the BF. The BF had full custody of the SC. The BM had not had any contact with the SC in extended period prior to the investigation.

OCFS Review Results:
ACS conducted the investigation according to New York State mandates.

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

CPS - Investigative History More Than Three Years Prior to the Fatality

Between 3/24/2011 and 5/5/2016, the family had 2 indicated SCR reports dated 3/24/2011 and 3/1/2012. The 3/24/2011 was an indicated because the BM wanted to home-school the now deceased SC and treat his medical needs herself. The report was indicated because the BM's underlying clinical health condition impacted her judgment regarding the SC's care.

On 3/1/2012, the BM was investigated because she had an emotional outburst in Nassau County Supreme Court during a divorce proceeding. She had to be taken to the psychiatric emergency room and the SC was placed in temporary foster care as a result. The allegation IG of the SC was SUB against the BM as she did not have an appropriate plan for the SC's care when she was hospitalized and would not disclose any contact information for the BF. The BM's actions created a serious risk to the SC since he had special needs (dietary, educational, therapeutic, mental health) and his placement had a negative impact on the SC receiving these services.

ACS was able to locate the BF who became a resource for the SC. On 3/7/2012, ACS filed an Article 10 Petition in Queens County Family Court. The BM was the respondent in the petition. The court released the SC to the non-respondent BF. The BM was granted supervised visitations with the SC.

Known CPS History Outside of NYS

The case documentation did not reflect the family was associated with any CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐ Yes ☒ No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No